Election Change Form

Flexible Spending Accounts (FSA)

Your election under the Flexible Spending Plan is irrevocable for the Plan Year, unless you experience a qualifying event and **your desired election change corresponds with that gain or loss of coverage**. The Health Care FSA Plan and the Dependent Care FSA Plan have slightly different rules regarding making an election change or enrolling mid-year.

When can I make a change to my Flexible Spending Account Elections?

You may change your election or enroll during the plan year if you, your spouse, or a dependent experience an event listed below which results in a **gain or loss of eligibility** for coverage under the State of Delaware Health Care Flexible Spending Account Plan or Dependent Care Flexible Spending Account Plan or a similar plan maintained by your spouse's employer or one of your dependent's employer and **your desired election change corresponds with that gain or loss of coverage**. Changes are only allowed if one of the specific events listed below has occurred that caused the needed change in your account.

Health Care FSA & Dependent Care FSA Plan Qualifying Events:

- Your legal marital status changes through marriage, divorce, death or annulment.
- Your number of dependents changes by reason of birth, adoption (or placement for adoption), or death. (If your child no longer qualifies for dependent care because he or she turned 13, then that is a loss of a dependent under the Dependent Care Flexible Spending Account Plan, but **not** under any of the other plans.)
- You, your spouse or any of your dependents have a change in employment status (termination, retirement, new employment, change from part time to full time or vice versa) that **affects eligibility for health insurance**.

Health Care FSA Plan Qualifying Events ONLY:

- You are served with a judgment, decree or court order, including a qualified medical child support order regarding coverage for a dependent.
- If you, your spouse or a dependent becomes **entitled to and covered under Medicare or Medicaid, you may drop or reduce coverage** under the Health Care Flexible Spending Account Plan.
- If you, your spouse or a dependent **loses eligibility and coverage under Medicare or Medicaid, you may add or increase coverage** under the Health Care Flexible Spending Account Plan.

Dependent Care FSA Plan Qualifying Events ONLY

- You change dependent care providers (including school or other free provider).
- You may make a corresponding change to your Dependent Care Flexible Spending Account if your dependent care provider who is not your relative changes your costs significantly.

How do I request the change to my Flexible Spending Account Elections?

If you have experienced one of the above qualifying events, please complete the **ELECTION CHANGE FORM** below and fax to the number listed below for review. **It is the employee's responsibility to file election change request within 31 days of the date of the qualifying event with the Statewide Benefits Office.** Requests received after 31 days from the qualifying event will not be approved.

For more information, visit the SBO website at **de.gov/statewidebenefits**.

Contact Statewide Benefits Office with Questions:

Phone: (800) 489-8933
Fax: (302) 739-8339
Email: benefits@state.de.us
Web: de.gov/statewidebenefits

Form Version 2018-12-07

Election Change Form

Flexible Spending Account (FSA)

State of Delaware

I understand that I may <u>ONLY</u> change my Health Care FSA or Dependent Care FSA Election(s) during the Plan Year if I experience a Qualifying Event and the election corresponds with that gain or loss of coverage as mandated by IRS Regulations.

❑ ELECTION CHANGE ❑ NEW ELECTION (Newly Benefit Eligible Employees **<u>Must</u>** Complete the FSA Enrollment Agreement)

Name (Last, First, MI)	Employee ID Number + Last 4 SSN	
	-	
Agency/School District Benefits Representative	**Plan Year**	**Date of Qualifying Event**
Agency/School District Name	**Daytime Phone Number**	

Completed form must be delivered to the Statewide Benefits Office <u>within 31 days</u> of the Qualifying Event. <u>Requests received after 31 days will not be approved</u>.

I certify that the following Qualifying Event has occurred:		
❑ Marriage	**Health Care Only** ❑ Judgment, Decree or Court Order* **Copy of Order Required*	**Dependent Care Only** ❑ Provider Cost Change
❑ Divorce (finalized)/ Annulment		
❑ Death - Spouse or Dependent	**Health Care Only** ❑ Gain or loss of eligibility and coverage under Medicare/Medicaid	**Dependent Care Only** ❑ Provider Change
❑ Birth, Adoption or placement of adoption of a child	❑ Dependent satisfies or ceases to satisfy eligibility Explain_____	**Dependent Care Only** ❑ Child turns age 13
❑ Change in Employment Status of Employee, Spouse or Dependent ❑ Check here if Employment Status Change is for spouse Explain_____		**Dependent Care Only** ❑ FMLA Begin ❑ FMLA End Date_____

I am requesting the following Benefit Election Change:		
❑ Health Care FSA* Original Annual Election $_____ New Annual Election $_____	❑ Dependent Care FSA* Original Annual Election $_____ New Annual Election $_____	❑ Stop Health Care FSA (*participation in plan will end*) ❑ Stop Dependent Care FSA **Pay period deductions will be recalculated based on new elections.*

If the election change request is approved, the new election amount will be effective for expenses incurred the first of the month following the latter of: **1)** the date of the event, or **2)** the date this form is signed.

I hereby certify that the indicated event has occurred and agree that this requested change corresponds with requirements as mandated by Internal Revenue Code Regulations. I understand that this election will remain in effect throughout the remainder of the current Plan Year, unless I experience another Qualifying Event.

Employee Signature _____ **Date** _____

RETURN THIS FORM TO STATEWIDE BENEFITS OFFICE BY FAX, (302)739-8339.
PLEASE CONTACT STATEWIDE BENEFITS OFFICE, AT (800)489-8933 WITH QUESTIONS.